PLAINTIFF'S COMPOSITE EXHIBIT B

Homestead Hospital

BAPTIST HEALTH SOUTH FLORIDA

7/4/2021

Patient Name: PAZDELSOL, ADISLEN
Account Number: [redacted]
Due Date: Upon Receipt

REQUEST FOR PAYMENT

Account Summary

Date of Service:	6/8/2021
Description of Service:	Emergency Department
Place of Service:	Homestead Hospital
Total Charges	$ 2,915.00
Insurance Payments / Adjustments	$ 0.00
Prior Patient Payments	$ 0.00
AMOUNT YOU OWE	**$ 2,915.00**

Pay online! It's fast, easy, and secure.
https://billpay.baptisthealth.net

VISA MasterCard AMERICAN EXPRESS DISCOVER

Scan this code to pay with your smart phone.

Our automated system provides up-to-date information about your account 24/7 at 786-596-6507 or toll free at 1-800-235-0065.

See reverse side of this statement for frequently asked questions.

IMPORTANT MESSAGE

We previously notified you that the balance due is your responsibility. However, our records indicate that you do not have insurance coverage. Therefore, you are responsible for the account balance due above. Please remit payment immediately. While it is our policy to work with all of our patients, your failure to remit payment in full or to contact us for financial assistance, requires that we submit your account to a collection agency. Pay online securely at: https://billpay.baptisthealth.net.

If you need help to pay your bill, please contact Customer Service Monday through Friday from 9:00 a.m. to 4:30 p.m. at 786-596-6507 or toll free at 1-800-235-0065 to ask about Baptist Health's Financial Assistance Program. Our Financial Assistance Program provides discounts for uninsured, eligible participants.

940412233

Statement64

Pay By Mail for Account Number: [redacted]

Amount Due	Due Date	Amount Enclosed
$ 2,915.00	Upon Receipt	$ _____

Homestead Hospital
BAPTIST HEALTH SOUTH FLORIDA
PO Box 830860
Miami, FL 33283

001954

BAP40C 2392267 29170906
PAZDELSOL, ADISLEN
[redacted]
HOMESTEAD, FL 33033-1502

Mail Payment Here

Homestead Hospital
PO Box 198116
Atlanta, GA 30384-8116

0000880045610000291500401008

Homestead Hospital
BAPTIST HEALTH SOUTH FLORIDA

6/20/2021

Patient Name: PAZDELSOL, ADISLEN
Account Number: [redacted]
Due Date: Upon Receipt

REQUEST FOR PAYMENT

Account Summary

Date of Service:	6/8/2021
Description of Service:	Emergency Department
Place of Service:	Homestead Hospital
Total Charges	$ 2,915.00
Insurance Payments / Adjustments	$ 0.00
Prior Patient Payments	$ 0.00
AMOUNT YOU OWE	**$ 2,915.00**

Pay online! It's fast, easy, and secure.
https://billpay.baptisthealth.net

VISA MasterCard AMERICAN EXPRESS DISCOVER

Scan this code to pay with your smart phone.

Our automated system provides up-to-date information about your account 24/7 at 786-596-6507 or toll free at 1-800-235-0065.

See reverse side of this statement for frequently asked questions.

IMPORTANT MESSAGE

Thank you for choosing Baptist Health South Florida to meet your healthcare needs. Our records indicate that you do not have insurance coverage and therefore, you are responsible for the account balance above. If our records are incorrect and you do have insurance coverage, please contact Customer Service immediately. Pay online securely at: https://billpay.baptisthealth.net.

If you need help to pay your bill, please contact Customer Service Monday through Friday from 9:00 a.m. to 4:30 p.m. at 786-596-6507 or toll free at 1-800-235-0065 to ask about Baptist Health's Financial Assistance Program. Our Financial Assistance Program provides discounts for uninsured, eligible participants.

940412233

Letter94

Pay By Mail for Account Number: [redacted]

Amount Due	Due Date	Amount Enclosed
$ 2,915.00	**Upon Receipt**	**$** _____

Homestead Hospital
BAPTIST HEALTH SOUTH FLORIDA
PO Box 830880
Miami, FL 33283

002363
BAP40C 2371929 22730661
PAZDELSOL, ADISLEN
[redacted]
HOMESTEAD, FL 33033-1502

Mail Payment Here

Homestead Hospital
PO Box 198116
Atlanta, GA 30384-8116

D0008800456100002915004010008

Homestead Hospital

BAPTIST HEALTH SOUTH FLORIDA

7/23/2021

Patient Name: PAZDELSOL, ADISLEN
Account Number: [redacted]
Due Date: Upon Receipt

REQUEST FOR PAYMENT

Account Summary

Date of Service:	6/8/2021
Description of Service:	Emergency Department
Place of Service:	Homestead Hospital
Total Charges	$ 2,915.00
Insurance Payments / Adjustments	$ 0.00
Prior Patient Payments	$ 0.00
AMOUNT YOU OWE	**$ 2,915.00**

Pay online! It's fast, easy, and secure.
https://billpay.baptisthealth.net

VISA MasterCard AMERICAN EXPRESS DISCOVER

Scan this code to pay with your smart phone.

Our automated system provides up-to-date information about your account 24/7 at 786-596-6507 or toll free at 1-800-235-0065.

See reverse side of this statement for frequently asked questions.

IMPORTANT MESSAGE

This is our third communication to you regarding the above account. Your account is now severely past due. Please be advised that this is your final communication from Baptist Health South Florida regarding your delinquent account. Pay online securely at: https://billpay.baptisthealth.net.

While it is our policy to work with all of our patients, your failure to remit payment in full, or to contact us to arrange payment, requires that we submit your account to a collection agency or attorney for further collection efforts.

If you need help to pay your bill, please contact Customer Service Monday through Friday from 9:00 a.m. to 4:30 p.m. at 786-596-6507 or toll free at 1-800-235-0065 to ask about Baptist Health's Financial Assistance Program. Our Financial Assistance Program provides discounts for uninsured, eligible participants.

940412233

Statement65

Pay By Mail for Account Number: [redacted]

Amount Due	Due Date	Amount Enclosed
$ 2,915.00	Upon Receipt	$ _____

Homestead Hospital
BAPTIST HEALTH SOUTH FLORIDA
PO Box 830680
Miami, FL 33283

000075

BAP40C 2419922 37803288
PAZDELSOL, ADISLEN
[redacted]
HOMESTEAD, FL 33033-1502

Mail Payment Here

Homestead Hospital
PO Box 198116
Atlanta, GA 30384-8116

00008800456100002915004010008

Homestead Hospital
BAPTIST HEALTH SOUTH FLORIDA

FREQUENTLY ASKED QUESTIONS & IMPORTANT PHONE NUMBERS

Frequently Asked Questions

Q. Do you offer financial assistance?

A. If you do not have any form of insurance and need help to pay your bill, please call the number below and ask about Baptist Health's Financial Assistance Program. Our Financial Assistance Program provides discounts for uninsured, eligible participants.

If you have any questions regarding your account, please contact our Customer Service Department Monday through Friday from 9:00 a.m. to 4:30 p.m. at 786-596-6507 or toll free at 1-800-235-0065.

Q. I've received a bill for a physician services. How can I find out more information?

A. If you've received a bill for physician services, please contact the physicians directly. Customer Service does not have access to any physician bills. Their contact information can be found on the physician bill you received.

Q. Can I pay my bill online?

A. Absolutely. Paying online is fast, easy, and secure 24 hours a day, 365 days a year. Log on to **https://billpay.baptisthealth.net** to get started. This service is free of charge.

Q. Can I pay my bill via phone?

A. Feel free to contact us at 786-596-6507 or toll free at 1-800-235-0065 to speak with a customer service representative who will help you process your payment.

Q. Can I pay my bill via check?

A. We accept payment by check. Simply flip this page over to fill out the form, detach, and mail it with your check to the address specified.

Q. When is Customer Service open?

A. Customer Service is open Monday through Friday from 9:00 a.m. to 4:30 p.m..

Important Phone Numbers

You may receive statements from your physician or other healthcare providers. If you have questions concerning other statements, please call the number listed on those statements.

Miami Cancer Institute Customer Service
(786) 594-6599

Baptist Health Medical Group
(786) 594-6880

Medical Records Department
(786) 596-6536

Baptist Health Patient Scheduling
(786) 573-6000 in Miami-Dade
(954) 837-1000 in Broward
(305) 434-1588 in Monroe County

CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

If you have new health insurance or a new address, please enter the information below. [redacted]

NEW ADDRESS	CITY	STATE ZIP CODE	NEW PHONE

POLICY HOLDER'S NAME/RELATIONSHIP TO PATIENT		POLICY ID # GROUP #	
EFFECTIVE DATE	BIRTH DATE OF INSURED	HMO/PPO/OTHER	INSURANCE PHONE #
IF GROUP INSURANCE, NAME OF GROUP (EMPLOYER, UNION/ASSOCIATION)			
INSURANCE COMPANY NAME		INSURANCE ADDRESS	
EMPLOYER		EMPLOYER ADDRESS	